

DATE OF INCIDENT: _____

ENTITY RESPONSIBLE FOR AED _____

AED USE REPORT

To be filled out each time an AED is attached to a patient

SUPERVISING PHYSICIAN:

Name: Andrew Michel, MD

Address: Saint Peter's Hospital, 2475 E Broadway, Helena, MT 59601

Phone No: 444-2150

Patient Age: _____ Patient Sex: ☐ Male ☐ Female

Location of Cardiac Arrest: _____

Estimated Time of Cardiac Arrest: _____ (use 24 hour time)

CPR Initiated Prior to Application of AED: ☐ YES ☐ NO

Cardiac Arrest Witnessed? ☐ YES ☐ NO

Time First Shock Delivered: _____ (use 24 hour time)

Total Number of Shocks: _____

Pulse After Shocking: ☐ YES ☐ NO If yes, was pulse sustained? ☐ YES ☐ NO

Patient Transported: ☐ YES ☐ NO

If transported, to where and by who? _____

INSTRUCTIONS:

1. Make a copy of this report and mail to: Department of Administration, General Services Division, Attn. Lou Antonick, PO Box 200110, Helena, MT. 59620-0110.